G. Hurtado Ruiz[1]
M. Roger Canals[2]
Ò. Alcoverro Fortuny[1]
N. López Patón[1]

An experience with multi-family groups in patients with schizophrenia

[1] CAEML
Sta. Coloma de Gramenet (Barcelona) (Spain)
[2] CSM Badalona I
Badalona (Barcelona) (Spain)

The experience of the application of McFarlane's multiple family group intervention in seven schizophrenic patients and their eigth caregivers in a middle-stay unit in order to improve burden and social support for the caregivers and to improve patient functioning is reported. A baseline evaluation and another post-intervention evaluation were made. Improvement in the knowledge about the disease and in the family burden was observed. Social support for the family and general functioning of the patient was not changed after family intervention.

Key words:
Schizophrenia. Multiple family group. Long stay unit. Family burden.

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Una experiencia con grupos multifamiliares en pacientes con esquizofrenia

Se expone la experiencia de la aplicación de los grupos multifamiliares de McFarlane a siete pacientes y sus ocho cuidadores en una unidad de media estancia para mejorar el conocimiento sobre la esquizofrenia, la carga y el apoyo social de los cuidadores y para optimizar el funcionamiento de los pacientes. Se realiza una evaluación basal y otra postintervención, observándose una mejoría del conocimiento de la enfermedad y de la carga de los familiares. El apoyo social familiar y el funcionamiento general del paciente no se modifica tras la intervención familiar.

Key words:
Esquizofrenia. Grupos multifamiliares. Unidad de media estancia. Carga familiar

CLINICAL NOTE

In the context of a middle-stay unit of a psychiatric hospital of the Barcelona province, the McFarlane multifamily intervention[1] was applied to a group of 7 patients diagnosed of schizophrenia or schizoaffective disorder and to their principal caregivers (n=8).

The intervention was evaluated, comparing the results of the group that received the intervention against another group having similar clinical and sociodemographic characteristics that received the conventional treatment. Two time periods were evaluated: baseline and post-intervention. The relatives were administered the CBI scale (Caregiver Burden Interview)[2] and CGHQ-28 scale (General Health Questionnaire-28 items)[3] to assess family burden, KASI (Knowledge About Schizophrenia Inventory)[4] to evaluate knowledge of the disease, DUFSS (Duke-UNK Functional Social Support questionnaire)[5] to evaluate social support perceived; and the patients were administered the GAF (Global Assessment of Function Scale)[6] to measure their global functioning, the BPRS (Brief Psychiatric Rating Scale)[7] to assess mental status and DUFFS scale of social support perceived.

The statistical program SPSS-10 for Windows was used for the descriptive analysis of samples (medians and standard deviation and absolute and relative frequencies) and comparison of the intervention-control groups (Mann-Whitney U test, Fisher's Test and chi-square test).

Patients of both groups had an evolution of the disease greater than 5 years, they were older than 18 years, had contact with their family at least once every 15 days. Baseline functioning level was low (GAF 40 $\pm$ 7). They had no current relapse. They took antipsychotic medication, with good compliance and followed a psychosocial rehabilitation program: psychoeducational groups and training in social skills, occupational therapy, training in basic daily life activities, individual interviews and support to the families. The caregivers and patients had no mental retardation, neurological or somatic disease nor Severe Mental Disorder (SMD) with current relapse that would interfere with the use of the interventions.

The intervention was based on the McFarlane multifamily intervention model[1]. The group was headed by 2 therapists.

Correspondencia:
Gemma Hurtado Ruiz
CAEML
Av. Prat de la Riba, 171
08921 Sta. Coloma de Gramenet (Barcelona) (Spain)
E-mail: hurtadorg@diba.es

The treatment protocol was initiated with 3 weekly sessions with each family and patient separately followed by 3 sessions of multifamily psychoeducation without the patients. One month later, all the families and patients were gathered together to initiate the training phase in problem solving and coping strategies with twice monthly sessions. The total duration of the treatment was one year.

Table 1 shows the results of both intervention and control groups.

At the onset of the treatment, the caregivers had significant burden, perceived scarce social support and had low level of knowledge on schizophrenia. The multifamily intervention improved knowledge on schizophrenia and reduced the family burden, but their perception of social support did not change. Regarding the patients, it was no more effective in the improvement of psychosocial functioning.

DISCUSSION

In the case of chronic patients, family burden appears in relationship with negative symptoms, disruptive symptoms and frequent psychiatric hospitalizations and with the limited knowledge and coping resources of the relatives[8]. In them, it is common to find resignation, resentment about previous contacts with professions, fear that the changes may makes things worse and lack of motivation[9].

Table 1 Multifamily intervention results

Patients (n = 7)	Group	Baseline[1]	Postintervention[1]	p
BPRS	GI	36±7.1	33.5±6.6	0.097
	GC	32±3.6	29±4.7	
GAF	GI	40±7.0	50±9.5	0.303
	GC	50±8.3	55±9.2	
DUFSS	GI	42.5±10.8	41.5±6.4	0.401
	GC	37±7.3	40.5±2.9	
Caregivers (n = 7)	**Group**	**Baseline[1]**	**Postintervention[1]**	**p**
KASI	GI	14±2.8	19±2.9	0.006
	GC	15.5±1.7	14.5±2.7	
CBI	GI	57.5±11.1	50±13.0	0.247
	GC	47±18.6	48.5±13.7	
GHQ-28	GI	8.5±8.3	3±9.2	0.043
	GC	3±6.0	3±8.9	
DUFSS	GI	34.5±8.2	36.5±14.2	0.792
	GC	42±12.6	35±9.6	

IG: intervention group (patients n = 7; caregivers n = 8). CG: control group (patients n = 7, caregivers n = 8); BPRS: Brief Psychiatric Rating Scale; GAF: Global Assessment of Function Scale; DUFSS: Duke-UNK Functional Social Support questionnaire; KASI: Knowledge About Schizophrenia Inventory; CBI: Caregiver Burden Interview; GHQ-28: General Health Questionnaire-28 items.

The family situation has a repercussion on the patient's course since those patients with families that have highly expressed emotion have more relapses[10].

Multifamily groups may have a positive effect on the family burden because they have been designed to reduce some of the patient-dependent risk factors and theoretically they increase the family management resources[8]. The McFarlane model includes four basic components: development of collaboration with the family, information on mental illness and resources available, teaching the family to cover their own needs and to use the available resources and services in the community and to improve communication skills and problem solving[1].

No studies have been published in our setting on this model, although different results can be expected given the differences in the emotion expressed in the families[11].

After the application of the intervention, we observed a reduction of the family burden, although other studies have different findings[8,10-14].

Three patients did not attend the sessions consistently. The multifamily groups may be indicated for some subtype of patients and relatives, the characteristics of which must still be defined[12].

Perception of social support in the families did not improve after the intervention, the same as in other studies[10,14]. This may be due to the treatment duration (1 years), less than that proposed by McFarlane[1].

Baseline functioning level of our patients was low and did not improve with family intervention, on the contrary to that found in the systematic review of Pharoah[10]. These results may be related with the chronicity of these patients.

At the onset of the intervention, knowledge of schizophrenia by the family is limited, in spite of the duration of the disease of the patients. In agreement with previous studies, family intervention has improved the caregiver's knowledge of schizophrenia[8,10,15]. This may also mean reduction of the stress symptoms and burden perceived by the family[15] and better treatment compliance.

Family intervention may have significant benefits, even for relatives with long-course schizophrenic patients, although the best would be to provide them as soon as possible, from the onset of the disease. The experience obtained in our center encourages us to consider that McFarlane's systematized and structured intervention can be an effective instrument, but well-designed clinical trials should be conducted to assess its efficacy in our setting.

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